

Nursing Professional Capital: A Qualitative Analysis

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Abstract

Objective: To offer qualitative support for the assertion that nurses possess professional capital.

Background: The term *capital* can be used in many ways to describe human contributions to institutions. Nurses embrace professional standards and tenets which have been measured as trust and ethics by quantitative public surveys. By understanding forms of capital and combining quantitative public-opinion surveys and our qualitative findings, a case can be made that nurses have accumulated professional capital.

Method: Focused review of existing interview data was conducted using inductive content analysis.

Findings: Participants provided unsolicited accounts of trust and positive regard for their nurses.

Conclusion: Evidence supports that nurses possess many forms of capital that, in combination with trust and positive regard, demonstrate professional capital. Nurses should be purposeful about protecting patient interests when spending professional capital that impacts institutional, political, and economic policy.

Introduction

A profession, in a general sense, is a group of people who are committed to the development of a discrete area of work and service. Professionals become expert in their field by acquiring a unique body of knowledge through rigorous academic study of principles, theory, and science (1, 2). Professionals accept the charge of the profession; adopt the language, attitudes, and behaviors of the profession; and develop “a clear sense of what their work is about and when it is effective” (2, p. 68). Furthermore, professionals “place service over professional gain” (3, p.1219) and are interested in public policy and social welfare. Professionals are held to a high standard of conduct by colleagues and by the public (1, 2).

Consistent with tenets of professional membership, nurses possess a publicly displayed ethical and moral commitment to patients (4). As a result, nurses have consistently been recognized by the public as the most trusted professionals (5, 6) and rated as very high or high on Gallup polls for honesty and ethics, a place they have held for the past 11 years (7, 8). Reasons for this status have not been detailed, nevertheless it can be inferred that adhering to the expectations of the profession coupled with many years of positive public regard have given nurses a great deal of *professional capital*. The purpose of this focused analysis is to describe and relate patients' perceptions of nurses to the concept of professional capital.

Capital

The term "capital" originated in economic theory in reference to money and material possessions that were assigned a certain value (9, 10). However, understanding capital as it relates to people has led to several concepts that preface the term capital such as human, intellectual (11), symbolic (12), social (12), and political (9) capital. These forms of capital are so interrelated that it is difficult to draw distinctions among them (12). For example, human capital refers to an individual's knowledge, skill, and experience while intellectual capital is the cumulative knowledge of all people who are within an institution. Intellectual capital is the outcome of organizational investment in individual professionals which, in turn, increases intellectual capital and positively impacts organizational performance (11, 13) such as improved quality and better patient health outcomes.

Symbolic capital

Because professional nurses offer a substantial amount of human and intellectual capital to the care of patients (9, 11) they have become crucial to the survival and advancement of an institution whose goal is to provide high quality healthcare. When an institution is perceived by the public as delivering high quality healthcare, it legitimizes the institution and when legitimacy is achieved, the institution is said to have obtained symbolic capital. For example, when healthcare institutions invest in nurses' human capital it results in higher levels of intellectual capital. This combination of human and intellectual capital improves patient care quality and thus boosts organizational outcomes (11) resulting in increased institutional symbolic capital (12).

Social capital

Social capital refers to reciprocal cooperation among community members that “captures ... the likelihood of mutual collaboration” (14, p. 686). Accordingly, professionals who claim a specialized area of healthcare practice are expected to improve patient outcomes through collaboration. When a common goal is desired and collaboration is preferred and expected, collective action moves forward even when an underlying power differential exists (15). Within healthcare institutions, collaborative relationships between various professionals (e.g. nurse-pharmacist, nurse-social worker, nurse-physician, and others) that contribute to the growth of social capital are important to the survival of the system. Positive team behaviors are necessary for institutional growth that result in positive public regard, increased symbolic capital, and overall benefit to the institution.

Political capital

Originally used to describe the influence of a politician within the United States Congress, political capital can be expanded to encompass the public’s beliefs about a person, group of people, or organization (9). Unlike previously discussed forms of capital, political capital must be earned, is given to one person by another, and can be collected or spent (9). Politicians are strategic about carefully spending their political capital in ways that positively impact public perception for the purpose of personal gain and re-election and the nursing profession is sometimes used in the political arena to increase politicians’ political capital.

Professional capital

The term professional capital has been used in educational reform (16) where it was described as a unification of human, social, and decisional capital (decisional capital means competency of judgment and evaluation). A similar concept, nurse *personal professional capital*, refers to a single person’s “public recognition of good care” (17, p. 149) whereas professional capital refers to public recognition of professionals in aggregate. High nurse professional standards have resulted in the acquisition of human, intellectual, symbolic, social, and political capital. However, nurses’ political capital has not often been in the national spotlight, likely because professional nurse organizations do not spend their political capital for personal or organizational gain. Rather, nurses use their professional influence to further the quality of patient care or to support policy that improves health outcomes for populations. Thus, the term *professional capital* is decidedly relevant for nurses.

Current evidence of professional capital

Polling companies have provided quantitative evidence of professional capital by annually surveying public opinions and reporting that nurses consistently score at or near the top of the scale for trust (18), honesty, and ethical behavior (5, 8). However single-question opinion polls provide little insight into reasons for such high regard and no evidence for how professional capital is earned by nurses. Qualitative research findings can add detail to quantitative data to legitimize a particular position (19, 20) and foster understanding of phenomena (21) such as professional capital. The purpose of this secondary analysis (see 22 for secondary analysis) was to describe patients' perceptions of nurses and to relate such perceptions to the concept of professional capital. The aim was to offer qualitative evidence to support the assertion that nurses possess professional capital.

Method

The primary grounded theory study (24) was conducted by the first author to explore the basic social process of feeling safe in intensive care using Strauss and Corbin's grounded theory method (23) and is reported elsewhere in detail (24). A semi-structured interview guide was used to query older adults' about experiences of feeling safe in an intensive care unit (ICU). Participants spontaneously shared their perceptions about the character and performance of nurses who cared for them during their hospitalization; data that were relevant to this report. We were impressed with the detailed description by participants about the nurses that spontaneously emerged in nearly every interview. Based on these descriptions, a secondary analysis using inductive content analysis (25, 26) is reported here.

Sample

For the primary grounded theory study (24) and for this secondary analysis, interview data were collected January thru July 2008. Participants were recruited from two Midwest teaching hospitals located approximately 230 miles apart; both served regional urban, suburban, and rural clientele. Ten patients ages 65 and older who met the inclusion criteria of (a) never having been a patient in an intensive care unit, (b) unexpectedly becoming seriously ill, and (c) receiving care in one of the hospital's ICUs were recruited and consented to be interviewed twice; once after discharge to an acute care unit and once after being home for approximately 2 weeks. The sub-sample for this focused secondary analysis was comprised of the eight participants (see Table 1 for demographics) who spontaneously shared their opinions about the nurses who cared for them in an ICU.

Data collection

Participants were interviewed first after being moved from the ICU to an acute hospital unit and again two weeks after returning home. A total of fourteen interviews comprised the subsample for secondary analysis. Two interviews were missing because one participant died before the second interview could be scheduled and another was discharged from the hospital before the first interview could be done. Interviews were audio-recorded, transcribed verbatim, and reviewed for accuracy. No new consents were necessary for secondary analysis because the original consent included permission for analysis of interview data about experiences in the ICU for subsequent use in publications and presentations. Study approval was obtained from a University Institutional Review Board (IRB), an institutional Nursing Research Council, and a hospital institutional IRB.

Data analysis

Transcriptions of interview data were analyzed using inductive content analysis (25, 26) by the authors who are experienced qualitative researchers. Data were independently hand-coded without the use of an electronic data management system because the limited volume of text was manageable. With a focus on professional capital, words, phrases, and sentences that signified the concept of interest were separated out for analysis. Transcripts were carefully read and thematic units (segments) were identified. Data were broken down into words and phrases that contained similar meanings, grouped together, and determined by the researchers to be distinct. Data segments that related to professional nurse behaviors and the perceptions of these behaviors by the participants were grouped based on commonalities.

Rigor

Credibility was demonstrated by the careful conduct of the original study. Data were collected by the first author and analyzed by both authors independently and then together to reach consensus. This process adds confirmation that conclusions reached by the authors accurately represent the data. Results are described and examples are provided so that findings are relevant to other settings and to larger populations (28).

Findings

Data analysis during the primary grounded theory study (24) provided evidence for positive public regard of nurses. Three subcategories identified in the primary study; *taking their word for it*, *they know just what to do*, and *I know they watch you*, will also be used to report secondary analysis findings. It is noteworthy that during the participants'

hospitalizations, there were no occurrences of life-threatening situations for any of them; they simply discussed their perceptions of the nurses and about how things worked or might have worked if “something happened” during their hospitalization.

Taking their word for it

Study participants had no experiences during their hospitalization that provided them evidence that the hospital employed qualified, knowledgeable nurses or the accuracy of what the nurses said; they were simply *taking their word for it*. Unfounded trust, described by Hardin (29) as “trust without grounds” (p. 70), means trusting someone without the demonstration of trustworthiness or adequate reason. However, the unfounded trust that was voiced by the participants provides evidence of nurse trustworthiness (31). The participants believed that the hospital held the patients’ best interest in mind by employing high quality nurses thereby providing evidence of institutional legitimacy (symbolic capital). Specifically, in reference to his ICU nurses, Mr. C said “You know, I don’t know whether they [the hospital] pick their nurses for that [meaning intensive care] or not.” Ms. F, in relation to a specific nurse who cared for her, described her notion of how nurses are assigned to work on specific units within the hospital. She believed that her nurse had the knowledge to work there as reflected by her statement, “Well, I figure, you know, that they’re experienced and everything in that work that she does, you know and that she’s assigned to that floor and all...”

The participants also trusted that the people who worked with them were qualified nurses and had confidence in their truthfulness. When asked if the person taking care of him was a nurse, Mr. A replied, “I’m sure he was qualified. I didn’t ask him for no credential but I’m sure he would not have been there at the hospital if he wasn’t.” One nurse, who had had a personal experience with a pacemaker and who was an expert in this area, shared his experience of having a pacemaker placed with Ms. F. After being scheduled for the procedure, Ms. F explained that her nurse “said he [the attending physician] was a good doctor, so that was confidence right there.” Ms. F “felt so reassured after I talked to them [the nurses] and they reassured me that everything was gonna be alright...” and Ms. G said “I never had any fear of what they asked me to do or what they told me or anything.”

They know just what to do

Evidence of patients' unfounded trust in their nurses' human capital was provided by five participants who believed that nurses "know just what to do..." Ms. F advanced unfounded trust when she expressed how her confidence in the nurses made her feel when she said that the nurses "know just what they're doing and that's why I said I felt so reassured." She also added, "because of the qualified nursing and their experience and everything because they know just what to do..." About a specific nurse who cared for Ms. F, her response included intellectual and human capital that translated to her beliefs about the institution.

Well, I figure, you know, that they're experienced and everything in that work that she does ... and I figure that she knows just exactly what she's doing in that one position ... and I figured that I'd be safe here too because they know what they're doing. In fact, I have all the confidence in the world in them.

When asked about how she thought the nurses came to know what to do, she explained the process that she believed brought the nurse to this particular institution,

Well, they're trained for that. They're trained in that one particular thing, I think that's why they're on the ICU floor and, they just know if any disaster or anything happens like that, they know just exactly what to do ... that's so reassuring because you don't know what to do for yourself and actually you're just laying there.

Ms. G demonstrated her unfounded trust when she shared her perception that the people taking care of her "knew what they were doing ... and I knew whatever they did, they were doing the best to do something to keep me alive. So I ... never had any fear of what they asked me to do or what they told me or anything." When asked how she knew that nurses knew what they were doing, her response was consistent with symbolic capital: "Well, they wouldn't be in the position they're in if they didn't know what they were doing or I hope they wouldn't be." She likened nurses to other professionals, "Just like a teacher or anyone else; you hope they know what they are doing. That's all you can. You just trust people. That's what you do... and I thought, it's in their hands. I'm alright." Although Mr. B did not specifically know about the nurses caring for him, he said about them, "Oh, I guess, I could tell they were quality, I knew their education, they're competent, they were very competent and they know what they're doing. And that was one of the biggest things. Seeing that I was in good hands." Ms. H expressed her unfounded trust of the nurses, "Now the RNs, they're definitely important 'cause they have the training and the knowhow," and Ms. D "just sort of let go and thought, 'They know what they're doing and I trust them'."

I know they watch you

Although some participants ($n=7$) discussed how important it was that they could see the nurses in the nursing stations, they did not always know exactly what the nurses were doing but they expressed confidence that the nurses were engaged in constant monitoring. Demonstrating unfounded trust, one participant simply stated, “I know they watch you.” During one interview, another participant explained his belief that he was being watched and, as a result, didn’t need to worry:

See, on that monitor, they know right out there at that desk every time my heart beats and they watch it so I wasn’t worryin’ ... and I know they watch you when your record is out there; you know it’s...they had a heart monitor on me. In other words the desk could see what my heart was doing all the time.

Ms. G reported similar perceptions when she said she “knew they were watching it constantly cause very seldom you looked out there I could see ... so I was on exhibit, I guess, all the time. But I could see ‘em out there and I knew they were watching the monitors.” During his stay in the ICU, Mr. B believed “the nurses’ station could see me all the time. I had a big glass door so I was being watched.” When he was transferred to a regular hospital room and although he could no longer see the nurses’ station, he said “they’re monitoring me right now.”

Participants discussed their perception that nurses were watching them either directly or through the monitoring systems. Mr. B “didn’t worry at all because ... the nurses’ station was right across from me so I knew I was being watched and being looked after.” He also thought, “well shoot, I’m better off with these people- they grew up with this stuff, so I felt confident that they, you know, they were, I was being watched and observed.” Advice that Ms. H would give to an older person about how to feel safe in intensive care was to “realize that there’s always someone there that your call button will get you, that they’re monitoring the heart monitor and the IVs are well handled, [and] that there is no reason to be fearful that you’re going to be left unattended.” She also explained that “the nurses’ station knows what your heart’s doin’. So, I felt alright about it. I assume that they had a fail-safe so if the thing wasn’t working that they would be alarmed.” Another participant “assumed that they had the monitors set correctly.”

Discussion

According to both historical and recent public surveys, nurses are regarded as one of the most ethical and trusted professions (5, 18). The purpose of this focused analysis (22, 30) was to provide qualitative data to support quantitative surveys as evidence for nurses' ongoing accumulation of nurses' professional capital. It is remarkable that patients who have no experience with being in critical care freely expressed their unfounded perceptions and beliefs that a) the hospital is intentional when nurses are hired and placed, b) nurses have a trustable body of knowledge, and c) nurses are continually watching them. These findings provided qualitative evidence that, when combined with existing surveys and polls, demonstrate the presence of human, intellectual, symbolic, and social capital and, coupled with evidence of unfounded trust, we conclude that nurses have earned and possess professional capital. To date, the concept of professional capital has not been used by the public or by nurses to describe their potential for influence. However, nurses could benefit from greater awareness and recognition of their own value related to professional capital. *We propose the concept of professional capital as a means of envisioning the valuable contribution and sleeping influence of nurses that may set the stage for a shift in the manner in which nurses, as professionals, are viewed and valued within healthcare systems.* More importantly, nurses must create a vision of their professional impact upon the survival of healthcare institutions.

A recent emphasis has been placed on estimating the professional and economic impact contributed by nurses to the healthcare system (32). Nurses contribute human and intellectual capital to the care delivery systems in which they work. This capital assists organizations in meeting outcomes that benefit and are valued by patients. Nurses also use social capital in concert with other health care providers to provide a team approach to patient care. Nurses act to optimize patient care. By contributing human and social capital to an institution and its related primary care subsidiaries, professional nurses enable the institution to develop intellectual capital within the system and symbolic capital (legitimation) outside the walls of the institution.

Keepnews (32) suggested that a more inclusive framework be considered, one that includes aspects difficult to quantify but "which are central to nursing's identity as a discipline focused on care and compassion" (p. 10). Tarlier (4) proposed that nurses make a difference in patient outcomes by engaging in "responsive relationships" (p. 236) characterized by respect, trust, and mutuality. Fletcher et al. (33) also emphasize the importance of relationships that

are formed between nurses and patients and added that often, to our detriment, the perspectives of patients are lost. Our findings are consistent with the notion that nurses' relational work (34) may not be recognized by the healthcare system but is visible and valuable when it comes to our professional standing with patients.

Limitations

Participants in this study were recruited at convenience and, by chance, are an ethnically homogenous sample which may have limited diversity of perspective. There were approximately 63% women in the subsample which is representative of the general population in the United States. Although sample size can be construed as a limitation, a small sample size is characteristic of qualitative research and the sample of 14 manuscripts seemed adequate for development of conceptual dimensions.

A second limitation was that the original study was about patients' perceptions of feeling safe in ICU and the interview guide did not include items about professional capital. Although the participants provided rich, unsolicited commentary about their nurses, the lack of focused questions about professional capital could have limited the depth of discussion. The problem lies in the potential for missing data during secondary analysis (22). This limitation was minimized by focusing on a naturally occurring phenomenon that was evident in data from eight of the ten participants.

Assessing the quality and nature of the original data set can sometimes be a challenge if the researchers were not involved in the collecting the original data set (22). When this problem is encountered, the researchers must contact the primary study team members (22). This was not considered an analytic challenge because the primary study interviews were conducted by the first author.

Conclusion

Nurses comprise the largest sector of healthcare professionals (40) and have consistently held top poll positions for the most trusted and ethical profession (5, 8, 18,). The likely reason for this sustained high regard is that nurses typically do not use their accumulated professional capital for personal or professional gain. Rather, nurses act in accordance with the definition of true professionals by demonstrating advancement of public policy that targets

social welfare. Healthcare systems around the world are facing unprecedented change (35). Healthcare policy and finance is generally organized within nations however trends and innovations have global impact (36). Consumer perceptions and expectations are challenging global healthcare systems and as each country reconfigures critical aspects of healthcare provision uncertainties follow that impact the demand for healthcare and the distribution of nurses (36, 37).

The healthcare environment is ready for reform lead by professionals who are willing to bypass self-interest and spearhead a comprehensive reform. Special interest groups that have self-interest focused influence over healthcare policy such as businesses, insurers, employers, and government and the key institutional players are physicians, administrators, and insurance companies (38). There is a glaring absence of nurses in the power mix. Nurses outnumber the other professionals (40), have the support of the public (5, 8, 18), and employ professional lobbyists (38) yet are perceived as having little influence over healthcare policy (38). Furthermore, nurses are imbedded in all aspects of healthcare and have first-hand knowledge of existing healthcare systems and how they work. No other profession is thus poised to lead the way. Perhaps spending some of the accrued professional capital in ways that improve health for the populations that we serve would be a place to start.

The role of nurses in health care reform will be an important factor in implementing change (35) and continued recognition and promotion of nurses as valued contributors to the process is critical. We suggest that nurses should, based on their sizable accumulation of professional capital, be purposeful and intentional about spending capital as a means of leading local, regional, and national reform and at the same time protect our political and economic place in healthcare systems (35, 39). During the process, we must keep the highly valued relationships we have established with our patients in the forefront.

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